I,	r other insurance benefits be made on neal information or documentation about the and any other payers or insurers, a vided by SJCFR, now or in the future. Sees provided to me and I assign all rightfor billing and collections purposes. I a	y SJCFR, regardless by behalf directly to to the to release to Meny information or do I agree to immediate to such payments also understand that S	of my insurance coverage. I SJCFR for any and all service edicare or Medicaid and their ecumentation needed to ely remit to SJCFR any to SJCFR.	
Patient or Representative Signature	Date			
Witness Signature	Date			
Patient unable to sign due to:				
Dear Patient:	INSURANCE INFORMATION			
You are responsible for paying your invoice unless your as be happy to file your insurance claim for your ambulance t unable to do so. Please provide this office with the follow are filing your own insurance claim and that payment will	transportation, however, without propeing information within 15 days. If it is	r consent and accura not received as requ	te information we will be tested, we will assume that you	
Patient Name	DOB	DOB		
Address	City	State	Zip	
Weekday Phone No.	Social Security #:			
Secondary Address	City	State	Zip	
Secondary Phone No				
	nto accident, please provide Auto Con Company and claim# - your employe			
TRANSPORT	RELATED TO: Auto Work	Health		
Name of Insured	DOB	Social Securi	ity #	
Name of Insurance Co	Insuranc	Insurance Phone		
Insurance Co. Claim Address				
Member#	Claim#_		Group#	
If CHAMPUS, please write ACTIVE or RETIRED and inc	dicate branch of service			
If involved in an auto accident, please list automobile in	nsurance as PRIMARY INSURANC	Е.		
SECONDARY INSURANCE (if an a	auto accident, please provide Auto C	ompany Insurance	and claim#)	
Name of Insured	DOB	Social Securit	y #	
Name of Insurance Co.	Insurance l	Phone		
Member#	Claim#		Group#	